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M e m o r a n d u m

To: Suzette Cheatham, Administrator
Winsor House Care Center

Date: April 11, 2011

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From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

On March 18, 2011, the Operation Guardian team conducted a surprise inspection of Winsor House Care Center in Vacaville. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS

1. Resident 10-04-01 indicated a Social Services note dated August 17, 2010, indicated the resident's denture were not fitting and an oral consultation would be implemented. The dental consultation notes available for review in the chart were dated October 5, 2010, and October 29, 2010 and there was no mention of the dentures not fitting appropriately. The medical chart revealed that this resident had "weight loss of 51.4 pounds since readmission." We observed the resident being transported to breakfast without her dentures (we found them in a cup by her bedside). The certified nurse's assistant (CNA) was questioned why the resident did not have the dentures in before breakfast. She stated the "dentures did not fit and were painful for the resident." CNA stated she would be glad to put the dentures in the resident's mouth, but the resident would simply remove them. It is unclear why this resident had not been evaluated for her proper fitting dentures. This negligent action by the facility could be contributing to this resident's severe, continuing weight loss.

2. Resident 10-04-02 was observed being transported in her wheelchair to the dining room for breakfast. She was later observed in the dining room crying uncontrollably and was not able to be redirected or consoled by the facility staff. Staff then returned her to her room where she continued to yell. Review of her medical chart indicated the medication Ativan "could be utilized for crying." The resident refused the medication and the yelling continued. Later in the morning, the resident was observed being transported via her wheelchair to the dining room for lunch. After her arrival in the dining room, she began to cry uncontrollably. Thus, causing a disruption to all other residents. The staff removed her from the dining room and as she was being taken out, she stated "I don't like it in there, take me back to my room." Review of the resident's Care Plan showed that there <u>was no</u> care plan for the resident's behavior and no plan for how to calm this resident when she became agitated. This resident's behavior was very disturbing for the other residents and especially her roommate.

3. The medical chart of resident 10-04-03 indicated on March 18, 2011 a telephone order was received by the nurses for the resident to have a speech screening and evaluation per Dr. Green. There was no documentation that the resident was having difficulty with swallowing or speech. It was also unclear why the resident was continuing to receive 24 hour skilled nursing care when the documentation indicated she had improved with physical therapy service. The DOJ nurse and physician interviewed

the rehabilitation staff and they reported their department determined when a resident could be discharged home from the facility not the nursing staff. Review of the Social Services documentation did not reflect discharge planning was in place. It should be noted that discharge planning is required to begin when the resident is admitted to the facility and not when the final decision for discharge has been determined.

4. The Operation Guardian (OG) Team reviewed the medical record of discharged resident 10-04-04 who was transferred to the acute care hospital for complications suffered after being given the wrong medications by a licensed nurse at the facility. On February 24, 2011 the resident who was in 12 B was given medication meant for the resident in 12 A. The chart lacked detailed charting regarding the incident. The single charting note regarding the error was a "Condition Change Form" dated 2/24/11 (no time was written that indicated the time of the error or time the physician was notified) stated "pt. (patient) was given medication for resident in 12 A. Pt. (patient) was notified & instructed if she feels anything different or doesn't feel well to notify nurse by using call light. Dr. Stock, on call for Dr. Green was immediately notified (again no time given) & gave orders to monitor for bleeding & somnolence, VS (vital signs) were checked every 30 min. (minutes) for remainder of shift. VS (vital signs) WNL (within normal limits), no respiratory distress noted." The family was not notified. The form also states that there was no change in condition or level of consciousness and that the nurses would continue to monitor for adverse reaction. At the time the form was written it stated "Resident was alert and & oriented. VS (vital signs) 128/64, 97.4, 72, 20, O2 (oxygen) sat (saturation) 96 %." The "Condition Change Form" was the only nurses' documentation on the resident for the entire day. There was no documentation for the resident from the time the wrong medications were given until the end of the shift

   The charting that started at approximately 12:00 midnight for 2/25/11 was not complete. Included was charting from the time the night shift took over care of the resident until she was transferred to the acute hospital unresponsive at 3:40 A.M. The resident's pulse was rising and her oxygen saturation was declining, however, that was not noted by the licensed staff until 3:30 A.M. when her oxygen saturation was critical at 83%.

   The only way the OG team found out the names of the wrong medications and what time the error occurred was that the Director of Nurses (DON) gave us the "Medication Error Report" which was not a part of the permanent chart. A complete review of the resident's medical chart was done and it could not be determined the names of the medication of the times they were administered. No facility transfer documentation was available in the chart that would have provided that vital information to the ED (emergency department) at the acute care hospital.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1. The oxygen storage located by the admissions office contained "e" tanks not properly secured in holders. It was difficult to determine which oxygen tanks were full vs. empty. Not all empty oxygen tanks were stored in the identified "empathy" area of the room. This could be a critical issue in the event of a resident emergency.

2. The treatment cart was observed with drawers #1 and #2 unlocked. The cart contains medicated

ointments and creams. This is a possible safety issue for confused residents.

3. The wheelchair belonging to the resident in Room 32 A required new vinyl to the right armrest. The cracked vinyl could easily cause skin tears to the fragile elder skin.

4. The resident in Room 29 C had poor oral hygiene.

5. Several resident beds were observed with half side rails utilized in the middle of the bed frame. This creates a "restraint" and was unsafe. The physician orders of the residents did not include an order for half side rails or for a restraint.

6. There were damaged floor tiles in some of the resident's rooms at the end of the "A" wing. The missing places in the floor tile could have caused residents with balance problems or walkers to fall.

7. The emergency exit on "A" wing was blocked with a wheelchair and food cart. The emergency exit on "C" wing was blocked with a Geri Chair and linen carts. This is a safety hazard.

8. All the shower rooms had new tile in the shower part of the room, however, all rooms smelled very unpleasant with a musty odor.

9. The "A" wing shower had unmarked personal care items sitting on a tile shelf next to a grab bar. The tile floor was very dirty. These are safety issues and infection control issues.

10. In Room 20 a suction machine hooked up to an uncovered "Yankauer" tip was sitting on the bedside table. This is an infection control issue.

11. Chemicals were noted to be unlocked in the Beauty Salon which was also unlocked. Again, a safety issue.

12. In Room 7 B there was an empty humidifier bottle connected to the oxygen concentrator. The bottle did not have a date marked.

ADMINISTRATIVE OBSERVATIONS:

The Operation Guardians Team requested in their entrance letter and again verbally for the facility to allow the team to review the "Incident/Accident Log"," Infection Control Log" and" Wound Care Log." The facility administrator informed the OG team that she was instructed by their legal counsel to refuse to let us review the documents.

The treatment book was reviewed for the month of March. It was noted that on the P.M. shift 14 residents had several blank spaces indicating that the treatments had not been done.

The Policy and Procedure for Medication Errors required management intervention to be more specific, as required by regulations.

The Medication Administrative Records (MARS) were not signed by the licensed nurses

administering medications.

It was unclear if the facility had reported the medication errors occurring on January 24, 201, February 14, 2011, February 24, 2011 and March 4, 2011 to the appropriate authorities. (DPH).

Physician orders for three charts reviewed, 12B, 19 B, 21 B and 22 A all had orders that read: "If patient has Medi-Cal ins. (insurance) available, hold bed X (times) 7 days (if transferred to acute hospital.) However, the Title 22 Section 72520 "Bed Hold" (a)(1) states "Upon transfer to a general acute care hospital, the patient or the patient's representative shall notify the skilled nursing facility within twenty-four hours after being informed of the right to have the bed held, if the patient desires the bed hold." This order doesn't address the patient or their representative's desire to have the bed held. A bed hold shall take effect only with the permission of the patient or their representative and not automatically when a Medi-Cal patient goes to an acute care hospital. This is not in accordance with Residents' Rights.

STAFFING:

The staffing levels are based on the records provided by the facility. Staffing levels were below the minimum required 3.2 hours per resident day (hprd) on one of the four days randomly reviewed.

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. Please send any comments to Sherry Huntsinger, NEII, at 1425 River Park Drive, Sacramento, California 95815. She may also be reached by telephone at (916) 263-1407.

Physician's Report – Operation Guardians
Kathryn Locatell, MD
March 29, 2011

Winsor House Vacaville
March 18, 2011

I. Summary

The care of six current or former residents was reviewed. In addition, we conducted direct observation of residents and resident care, reviewed a variety of documents on site and interviewed the director of nurses and other staff. There were deficient facility practices in the areas of pain management, infection control, physical restraints, weight loss and nursing services in general.

II. Pain management

One recently deceased resident (Resident 5; died 3/10/11) was identified as having extremely poor pain and other symptom management. Resident 5 was admitted to the nursing home from an acute care hospital on 2/5/11 and again after being hospitalized on 3/2/11. She was 44 years old and suffering from advanced, metastatic cervical cancer. The disease process caused severe pain and also a small bowel obstruction which caused nausea and vomiting. A number of deficiencies of care were identified through review of her records, primary of which was the failure to adequately manage her pain and other symptoms as she was dying.

Review of the 24-hour nursing reports showed that she was identified has having had a change of condition on 3/7; she had pulled out the nasogastric tube that was being used to manage symptoms related to the small bowel obstruction. However, subsequent to 3/7, there were no further entries in the 24-hour log following up on this change. The narrative nursing notes likewise had no entries concerning what measures were being taken to address the pain, nausea and vomiting she was experiencing for a 48-hour time span afterwards. An entry on 3/7 at 4:30 pm was followed by the next entry on 3/9 at 6 pm, while the medication administration record showed that she was having out of control pain and nausea continuously during this time with maximum administration of the drugs prescribed to control these symptoms. No assessments were documented; her physician and hospice providers were not notified. On the day of her death, these symptoms became even more severe according to both the narrative entries and the MAR. As a physician who has treated numerous such patients, I was appalled by this apparent neglect of Resident 5; she died a miserable death due to the facility's failure to take appropriate action on her behalf over the course of (at least) 3 days. I advised the director of nursing of my findings and recommended immediate action to prevent other dying residents from suffering a similar fate.

III. Infection control

Review of the 24-hour reports also showed that quite a few of the 53 current residents were receiving antibiotics at the time of our inspection. Several cases of *C. difficile* (intestinal infection, communicable, related to antibiotic therapy) were also identified. We asked the director of nursing about this and she was unable to identify what infection control monitoring was being carried out and referred us to the director of staff development. The infection control logs requested were not provided. Based on these findings, it appears that the facility lacks appropriate infection control monitoring, potentially exposing numerous residents to avoidable infections.

IV. Physical restraints

We observed a potentially dangerous practice of using side rails as restraint devices for numerous residents. During a walk-through while many residents were in bed, we observed a half-side rail in the raised position at the mid-point of the bed. A raised half-rail in this position effectively blocks a resident from being able to get out of bed, since it obstructed the location where the resident would place the feet and when sitting up from a reclining position. I demonstrated this to the director of nurses who was appeared to be unaware that the use of the rails in this position presented a safety hazard to residents, who might attempt to climb over the rail in an effort to get out of bed. In the case demonstrated, the person (Resident 3) was known to be at high risk for falling and had the bed in the lowest position with a mat on the floor. There was no order or consent for the rail to be used in this fashion, as a restraint device, in violation of the standard of care. Another resident with the half-rail raised in this way did not have a low bed or a mat on the floor; if this resident climbed over the rail, there was a potential for serious injury.

V. Weight loss

The facility's weight logs were reviewed, and a number of residents had experienced recent, significant weight loss. At least 7 such residents were identified, a high proportion of the 50-odd inhabitants of the facility. There appeared to have been inadequate nursing monitoring of the weight loss, as in no case did the 24-hour nursing reports reference these recent drops in weight. In one case, Resident 6 was noted in the 24-hour report to have been referred for a speech therapy screen. Her weight has been steadily dropping since admission to the facility on 2/23/11 yet there were no nursing assessments of her eating patterns found in the medical record. Nor was there any documentation by nursing regarding the reason for a speech therapy referral.

VI. Nursing services and processes of care

A number of deficient practices were identified during the one-day inspection. The first concerns medication administration. Review of the MARs showed that there were several recent (3/11) instances where residents did not receive ordered medications because the drugs had not been obtained from the pharmacy. Resident 5 was also

affected by this practice and did not receive the long-acting morphine ordered for many shifts in a row (during her 2/5/11 period of residence). The director of nursing was unaware of either the frequency which with this was occurring or why drugs weren't available. I recommended an immediate investigation and analysis of this problem, as the entire population of residents could potentially suffer adverse consequences of not receiving necessary drugs ordered by their physicians.

The next concerns staffing of the nursing department. Given the high acuity level of residents in the facility (15 currently receiving skilled care under Medicare Part A), the staffing ratios for certified nursing assistants cited by the director of nurses seems far too low. The CNAs we observed during the inspections seemed rushed and harried; most said they had been assigned 8 residents each (the DON stated that the usual ratio was 1:7 on the day shift). The stated ratio for the pm shift of 1:12 or 1:13 seems extremely low given the acuity of the residents. Also, there are currently 5 residents receiving tube feeding, a high proportion, and such residents require much more licensed nurse time than residents who eat on their own. The DON has instituted around-the-clock staffing with a registered nurse; however it appears that the RN is not conducting resident assessments but rather is acting simply as a charge nurse. An RN supervisor had resigned the day before our inspection, per the DON to take a job with higher wages.

Finally, I am concerned that licensed nurses are not adequately monitoring residents' conditions and that they are not being adequately supervised. Review of the 24-hour reports was instructive in this regard. Nurses are listing mainly the residents who are receiving antibiotics. There is no evidence that the DON (or a supervisor) is reviewing the reports. While residents on antibiotics constitute one class of residents for whom shift-by-shift monitoring (and thus reporting in the 24-hour log) is appropriate, any resident who experiences a change of condition should have such monitoring. The 24-hour log is a key tool for ensuring all nurses, on every shift, are aware of the need to monitor residents who have had a change in condition; it is not practical and rarely possible to communicate verbally about every resident who needs heightened monitoring. The DON has been in this role for only a few months and was never previously a director of nurses. It appears that she needs more training and support to put effective systems in place to ensure that residents are well cared for.

VII. Conclusions

The facility appears to be emphasizing its ability to provide "post acute" care, yet at the present times lacks sufficient nursing personnel to accomplish this in conformance with current standards. Given the high acuity of residents currently being served, more effort to ensure nursing care meets standards is needed. Immediate attention to pain management and medication administration is needed. The facility should evaluate its staffing plan to determine whether it is adequate to meet the needs of current and future residents.